

**ELECTRONIC REMITTANCE ADVICE AND PAYMENT CYCLE
ENROLLMENT FORM**

Provider #: _____

Provider Name: _____

Address: _____

City: _____

Phone Number: _____

Contact Name: _____

E-mail Address: _____

***Providers enrolling as of 01/01/04 for new DPHHS provider numbers can only select EFT options. Choosing any other option will mean that your form will be returned.

	Payment Method	Remittance Advice	Payments Received
Option 1	EFT	Electronic	Weekly
Option 2	EFT	Paper	Bi-Weekly

Please refer to the table above and indicate the Option that you want: _____

Provider Agreement: I agree to participate in the Department of Public Health and Human Services' Electronic Remittance Advice project. I understand that participation will require some time and effort on the part of myself or my office staff. I accept responsibility for accessing the Montana Eligibility and Payment System website and downloading the Electronic Remittance or an X12N 835 Remittance Advice from ACS EDI Gateway. I understand that the only way to receive weekly payments is to receive both Electronic Remittance Advice and Electronic Funds Transfer. At any time I may inform DPHHS in writing that I wish to discontinue receiving my Remittance Advice electronically, but also understand that then I can no longer receive weekly payments.

Provider Signature

Date

Please mail this completed form to:

ACS Provider Relations
P.O. Box 4936
Helena, MT 59604